commission for children and young people and child guardian

A better life for Queensland children

Child Guardian Report:

Investigation into the Use of Force in Queensland youth detention centres

October 2012

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All enquiries regarding this document should be directed in the first instance to:

Director, Systemic Monitoring and Review Program

Commission for Children and Young People and Child Guardian

OfficeoftheQueenslandChildrensCommissioner@ccypcg.qld.gov.au

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1. Executive Summary

1.1 Purpose of the investigation

The Commission for Children and Young People and Child Guardian (the Commission) has the legislative responsibility to promote and protect the rights, interests and wellbeing of children and young people in Queensland. In particular, section 23(1)(e)(i) of the Commission's Act prescribes that the Commission must prioritise the needs and interests of young people detained in youth detention centres in Queensland.

In fulfilling this responsibility, the Commission has identified concerns about the use of force by officers of the former Department of Communities (the Department) in both Queensland youth detention facilities, namely Brisbane Youth Detention Centre (BYDC) and Cleveland Youth Detention Centre (CYDC).

The identification of use of force as an issue requiring investigation was raised during the ongoing regular review and analysis of a variety of sources that inform the Commission's monitoring and advocacy functions, including the:

- Youth detention inspections conducted by the Department under section 263 of the *Youth Justice Act 1992* on a quarterly basis
- Reports of harm and suspected harm in youth detention centres provided by the Department on a monthly basis in accordance with section 37 of the *Youth Justice Regulation 2003*
- Commission Community Visitor reports completed after monthly visits to young people in youth detention centres under Chapter 5 of the *Commission for Children and Young People and Child Guardian Act 2000*, and
- Complaints received by the Commission from young people detained in youth detention centres, about the use of force under Chapter 4 of the *Commission for Children and Young People and Child Guardian Act 2000*.

1.2 Jurisdiction and terms of reference

This investigation was undertaken following the identification of six instances where young people had suffered significant injuries as a result of the use of force. The injuries included:

- Dislocated shoulder and fractured upper arm (1 young person)
- Wrist fractures (4 young people), and
- Fractured radius (forearm) (1 young person)

The Commission has the functions of monitoring and reviewing laws, policies and practices that relate to the delivery of services to children and has an obligation to give priority to the needs and interests of children who are living under detention in a detention centre in Queensland.

The Commission commenced this investigation under the Commission's Act under the following terms of reference (TOR):

TOR 1 Review the appropriateness of the policies, procedures and training in place in relation to the use of force at the time of the six events resulting in significant injuries

TOR 2 Review the appropriateness of the force used in the six events resulting in significant injuries, with a view to identifying any systemic issues, and

TOR 3 Review whether appropriate complaint, harm and other mandatory reporting and referral processes were followed

1.3 Information relied on for this investigation

The Commission made a formal notice of an investigation to the Department under section 63 of the Commission's Act, accompanied by a notice requesting information under section 67 of the Commission's Act.

In accordance with these notices, the Department provided the following information to the Commission to inform the investigation. The Department's response to the Commission entailed:

- a letter responding to the issue of use of force
- a summary document responding to the specific incidents of complaint involving six young people who were the subject of the investigation
- documentation from both detention centres in relation to the six specific cases where young people have sustained injuries (specifically broken bones) which appear to have occurred in the course of detention centre staff applying force/protective actions/restraint techniques
- The Department provided the following suite of policies and procedures to inform the investigation:
    - the Youth Detention Centre, Protective Actions Induction Training Package
    - the Centre Directive – Use of Restraints
    - Operational Policy Statement – Accessing services – complaints management (YDC-010-01)
    - Operational Procedure – Accessing services – complaints management (YDC-010-01)
    - Operational Policy Statement – Safety and security – incident reporting (YDC-015-01)
    - Operational Procedure – Safety and security – incident reporting (YDC-015-01)

- Operational Policy Statement – Case management – identifying and reporting harm (YDC-016-01)
- Operational Procedure – Case management – identifying and reporting harm (YDC-016-01).

1.4 Methodology

This report is based on the Commission's analysis and review of the documents provided by the Department as outlined above and makes recommendations relevant to the:

- Mechanisms in place to guide officers' use of force when restraining young people in Queensland youth detention centres
- Practice of officers in exercising use of force on detained young people in Queensland youth detention centres, and
- Outcomes experienced by young people in Queensland youth detention centres resulting from officers' use of force.

The Commission did not consider it necessary to undertake formal interviews with Department staff or detained young people as part of this investigation.

1.5 Procedural fairness

Section 50 of the Commission's Act provides the Commissioner with the power to make recommendations. Before making these recommendations the Commissioner is required to give the service provider a written copy of the proposed recommendations and a reasonable opportunity to comment on them.

Section 85(1) of the Commission's Act specifies that the Commissioner must not include in a report any comments adverse to an entity identifiable from the report, unless the entity has been given a copy of the comments and a reasonable opportunity to respond to them.

Accordingly, this Report was provided to the Department of Justice and Attorney-General as the relevant service provider in provisional form for review and response. All of the Department's comments in relation to the provisional recommendations have been incorporated in this final report version of the report.

The Commission has made 12 Final Recommendations in this Report.

1.6 De-identification

This report de-identifies both Queensland youth detention centres and the six young people that are subject to this investigation.

1.7 Summary of Opinions and Recommendations

TOR 1 ***Review the appropriateness of the policies, procedures and training in place in relation to the use of force at the time of the six events resulting in significant injuries***

Commission Opinion 1: The justifications for the use of force in the legislation are focused on protection rather than merely compliance. This is in contrast to the focus of some of the supporting documents prepared by the Department. It is essential that the information provided on the use of force in the policy and procedure documents and the training materials are an accurate reflection of the legislation.

Recommendation 1: The Commission recommends that within three months the Department finalise its review and update of policy and procedural documents and training materials referencing use of force to ensure they are an accurate reflection of the relevant legislation. Should any doubt exist, about the legality of these documents or materials, the Commission further recommends that the Department seek legal advice and update the policy and procedural documents and training materials with reference to this legal advice.

Recommendation 2: The Commission recommends that the Department, in its review of training materials on the use of force (in the next three months), incorporates staff training on the range of situations frontline workers (particularly youth workers and section supervisors) may be faced with and include strategies to deal with uncooperative behaviour prior to escalation.

Recommendation 3: The Commission recommends that staff members (particularly youth workers and section supervisors) be provided with regular training which includes the legislative framework for their duties and explains the appropriate circumstances and limits in legislation in relation to the use of force and the associated oversight mechanisms established to monitor youth detention centres in Queensland.

Recommendation 4: The Commission recommends that the Department continue to work with relevant unions or other employee representative groups to confirm knowledge and understanding of the legislative limits on the use of force, and de-escalation techniques to help prevent the use of force, as core competencies for any individuals currently working, or wishing to work, as youth workers or their supervisors within Queensland youth detention centres.

TOR 2 Review the appropriateness of the force used in the six events resulting in significant injuries

Commission Opinion 2: The six incidents highlight the potential problems with the force techniques approved for use on young people in youth detention centres. Based on the information provided, it appears that the 'pain compliance/management' holds are currently the only approved techniques for use in the detention centres[1] and these may not be appropriate for use on young people as evidenced by the resulting injuries.

Recommendation 5: The Commission recommends that the Department continue its review of the suitability of the use of force techniques approved for use on young people in youth detention centres and finalise within three months. As part of this review the Commission recommends that advice is obtained from a relevant expert on the safety and appropriateness of the techniques currently approved for use on young people. The Commission also recommends that the Department review the lawfulness of the techniques used, particularly in relation to the 'pain compliance/management' holds and the circumstances under which these techniques could be considered reasonable.

Commission Opinion 3: The six incidents highlight the potential for injury to young people as a result of the use of force by officers, such that the offering of medical assessments following such events should be mandated in all staff training materials.

Recommendation 6: The Commission recommends within the next three months that the Department state in policy and procedures that medical assessment is to be offered promptly to young people who are involved in a serious physical altercation with another person or when force is used on a young person by a staff member.

Recommendation 7: The Commission recommends that the Department provide the Commission with further advice as to the investigations undertaken into the incidents involving the six young people, including:

- the outcomes of each of the investigations and any actions taken by the Department as a result, and
- advice as to how the Department kept the young people informed of the investigations' progress and outcomes, regardless of whether they were in detention at the time of completion.

[1] The Department has indicated that the use of hand cuffs has replaced the transport wrist lock technique over long distances. This issue of the use of handcuffs is dealt with in further detail in section 6.1 of this report.

Commission Opinion 4: Even if the use of force was lawful and justified in the six incidents, the injuries sustained by the young people indicate that the amount of force used was disproportionate to the risk presented in some of the circumstances. Significant differences in size, weight and strength exist between some young people and youth workers, which are relevant to the use of force, but do not appear to have been adequately considered by the officers.

Recommendation 8: The Commission recommends that the review of the approved techniques under the staff training take into consideration:

- the various factors raised by each of the incidents under this investigation, including the behaviours exhibited by the young people prior to the use of force
- whether or not these actions justified the use of force (under the provisions of the Regulation and Department's associated policies and procedures)
- the specific technique and amount of force used in applying this technique
- consideration of the specific physical characteristics or disability of the young person in determining what (if any) level of force to apply in a situation, and
- how staff should undertake the debriefing of a situation with a young person following the use of force on that young person.

Commission Opinion 5: While restraints such as handcuffs may be required in certain circumstances, these circumstances are limited, as outlined in the provisions of the Youth Justice Regulation 2003. Utilising handcuffs as the sole replacement to the 'transport wrist lock technique' therefore requires detailed consideration in policy, procedural and training contexts.

Recommendation 9: The Commission recommends that the inspections (under section 263 of the *Youth Justice Act 1992)* periodically review the use of restraints (including handcuffs) across both detention centres to confirm the information provided to staff on their use and current practice aligns with the provisions of the *Youth Justice Regulation 2003*.

TOR 3 Review whether appropriate complaint, harm and other mandatory reporting and referral processes were followed

Commission Opinion 6: The incident documents of the six young people examined under this investigation highlight the importance of an accountable and transparent complaints management system for both young people and people acting on their behalf such as care-givers and relatives.

Recommendation 10: The Commission recommends that the Department confirm within three months that its revised complaints and incident management policy, procedures and training materials, detail a clear incident referral process to internal accountability mechanisms (such as the Department's Ethical Standards Unit) and external entities (such as the Commission, the Queensland Ombudsman and CMC).

Recommendation 11: The Commission recommends that the Department confirm within three months that internal accountability mechanisms exist to ensure complaints raised by young people with the Department are acted on in a timely manner and that complainants are updated at a minimum of a monthly basis of the progress of the matter.

Recommendation 12: The Commission recommends that the Department consider the analysis, findings and recommendations contained in this Investigation report and Recommendation 15 from the Forde Inquiry, and confirm its revised Complaints and Incident Management policies and associated operational procedures and staff training are appropriately aligned and "young person friendly".

2. Mechanisms that guide 'Use of Force'

2.1 Overview

Youth Detention Centres are governed by the *Youth Justice Act 1992* and the *Youth Justice Regulation 2003* and are managed by the Department.

There are currently two Youth Detention Centres in Queensland:

- BYDC, located at Wacol, accommodates females from across the state, and males from south of Rockhampton, and
- CYDC, located in Townsville, accommodates only males from north of Rockhampton.

The mechanisms that guide the use of force in these youth detention centres include:

1. Legislation
2. Policies and procedures
3. Training and supervision of Departmental officers, and
4. Internal and external oversight mechanisms.

2.2 Legislation

The use of force in youth detention centres in Queensland is regulated by section 17 of the *Youth Justice Regulation 2003* (the Regulation).

- Section 17 (5) of the Regulation specifies that *a detention centre employee may use reasonable force to protect a child, or other persons or property in the centre, from the consequences of a child's misbehaviour*.
- Section 17 (6) states that *a detention centre employee may use the force only if the employee reasonably believes the child, person or property can not be protected in another way*.
- Section 17 (7) specifies that *if a detention centre employee uses force under subsection (5) –*
    - *the detention centre employee must not use more force than is reasonably necessary; and*
    - *the chief executive must ensure details about the use of the force are recorded in a document kept at the detention centre*.

The *Youth Justice Act 1992* outlines safety and security provisions in relation to the chief executive's role in managing detention centres.

- Section 263 (1) states the *chief executive is responsible for the security and management of detention centres and the safe custody and wellbeing of children detained in detention centres.*
- Section 263 (3c) states the *chief executive is responsible for maintaining discipline and good order in the centre*.
- Section 263 (3d) states the *chief executive is responsible for maintaining the security and management of the centre*.

2.3 Departmental policy and procedure

The Department's policy statement in relation to the use of force specifies that:

> '*youth detention staff will respond to incidents in a manner which ensures the safety of young people and staff and utilises use of force, restraints and/or separation as a last resort to managing threats of harm posed by young people, towards persons and property*'.[2]

Generally this policy appears to be sound in relation to the management of use of force in a detention environment and refers to the authority for the policy as the relevant provisions of the *Youth Justice Act 1992* and the *Youth Justice Regulation 2003*.

The accompanying procedural document, Operational Procedure Safety and Security – incident response YDC-034-02, explains that prior to using force:

> '*staff must utilise intervention strategies that are aimed at diffusing (sic) potentially volatile and/or confrontational situations*'[3].

The strategies listed include:

> *'withdrawing from the situation to allow the young person to de-escalate*
>
> *if it is safe for the young person and other young people, use of appropriate communication skills and negotiation skills leading to a "win win" situation*
>
> *removing the "audience" where this is possible and appropriate, and*
>
> *removing young people from the group for one-to-one counselling and for a cooling off period'*[4].

This emphasises the importance of attempting other means of managing a situation prior to using force, which is consistent with the provisions of the Regulation in terms of force being used only if protection of the child, person or property cannot be achieved another way.

[2] Operational Policy Statement, Safety and security – incident response, YDC-034-02.
[3] Operational Procedure, Safety and Security - Incident response (YDC-034-02)
[4] Operational Procedure, Safety and Security - Incident response (YDC-034-02)

However, there are sections of the procedure document which appear to be inconsistent with the legislation. This procedure document defines 'use of force' as '*when young people are made, against their will, to comply with a reasonable or proper order or direction from a person so authorised to direct or order'*.[5]

This definition is not consistent with the reasons which may allow force to be used as outlined in the *Youth Justice Regulation 2003*. Under section 17(5) of the Regulation, a detention centre employee may use reasonable force only '*to protect a child, or other persons or property in the centre, from the consequences of the child's misbehaviour*.'

The Regulation does not state that force can be used to gain compliance from a young person with a reasonable or proper order or direction. If a young person does not comply with a reasonable or proper order or direction this does not necessarily mean that a child or other persons or property in the centre will need to be protected.

The definition of the use of force as outlined in the Department's procedure document is also reflected in the contents of the Department's training packages on the use of force.

2.4 Training Resources

The Youth Detention Centre Training Protective Actions Participant Course Notes (Course Notes) provide the following definition for the use of force – '*when young people are made, against their will, to comply with a reasonable or proper order or direction from a person so authorised to direct or order*'.[6]

As with the definition provided in the Operational Procedure (aforementioned) this definition does not appear to be consistent with how the use of force is dealt with in the *Youth Justice Regulation 2003* (the Regulation).

With regard to the behaviour of young people, the *Youth Justice Regulation 2003* specifies:

- *section 17(1) that a child detained in a detention centre must obey a reasonable instruction lawfully given to the child by a detention centre employee*
- *section 17(2) that if a child in a detention centre does not obey an instruction mentioned in subsection (1), or otherwise misbehaves, the chief executive may discipline the child*
- *section 17(4) that the Chief executive must not use as a way of disciplining a child (a) use of corporal punishment or (b) physical contact*
- section 17(5) *that a detention centre employee may use reasonable force to protect a child, or other persons or property in the centre, from the consequences of a child's misbehaviour*

These sections of the Regulation prescribe a focus on protection rather than mere compliance with staff directions. In contrast, much of the Department's training materials focus largely on compliance rather than protection and safety considerations.

[5] Operational Procedure, Safety and Security - Incident response (YDC-034-02)
[6] This definition is similar to what appears in the Operational Procedure, Safety and Security – incident response, YDC-034-02.

The Course Notes outline 'Principles of Controlling Resistive Behaviour' stating 'Generally, all person control techniques utilise one of these 'principles' -

Pain Compliance	*The use of stimulus or pain to influence and control resistive behaviour. Through joint manipulation, pressure is applied whilst verbal commands are given. The pressure and pain are alleviated when commands are obeyed and the person becomes cooperative.*
Distraction Techniques	*Protective Action techniques that weaken motor action by changing the thought process to allow follow up control techniques. This can shift the person's concentration by diverting thoughts from offensive to defensive eg yelling.*
Balance Displacement	*Protective Action techniques that decentralise weight through principles of leverage, providing a distraction proceeding a joint lock control. A person's ability to use strength or mobility is greatly reduced when they're off-balance.*

No other 'principles' are presented in the training materials which may be used to control resistive behaviour.

The *Protective Actions – Induction Training Package* (the Training Package) details the various approved techniques[7] and their expected effects. For the purposes of this Investigation Report the Protective Actions have been summarised at Attachment A. The summary includes the Force Category, Expected Effects and Medical Implications for each method of restraint used.

Table 1 – Approved techniques and their expected effects

Technique	Expected effects
Transport wrist lock	Immobilisation of the affected arm. Medium to high levels of pain.
Straight arm bar	Young person is controlled through immobilisation of the affected arm.
Reverse wrist lock	Immobilisation of the affected arm. Medium to high levels of pain.
Two person take down	Not specified.
Three person room insertion	Not specified.
Three person room removal.	Not specified.

[7] Page 20-28 of the Protective Actions – Induction Training Package.

As illustrated in Table 1, the Training Package seems to indicate that the approved techniques are focused on pain compliance as the stated expected effects and are "medium to high levels of pain"[8].

Table 2 – Definitions of Categories of Force

Category	Definitions
Category 1	A cooperative subject requires no force other than placing hand on to guide or comfort. Command presence and bearing.
Category 2	Grips, pain compliance, joint manipulation techniques.
Category 3	Grips, pain compliance, joint manipulation techniques plus distraction.
Category 4	Grips, pain compliance, joint manipulation techniques, distraction plus restraining equipment.
Category 5	Grips, pain compliance, joint manipulation techniques, distraction, restraining equipment, plus self-defence'.

While the Commission is conscious that detention centre's staff training resources must focus on maintaining the security, protection and safety of both young people and staff. Greater clarity and emphasis should be placed on the protective aspects as outlined in section 17(5) of the *Youth Justice Regulation 2003,* which specifically deals with the use of force rather than merely on notions of control and obedience.

Although section 17(1) specifies that a young person must obey directions it does not actually authorise the use of force to gain compliance from the young person. The focus on using 'protective actions' on 'highly un-cooperative' people potentially further blurs the limitations on the use of force as outlined in the Regulation. A focus on compliance and control rather than safety and protection may also lead to situations where force is used to excess.

The *Protective Actions Participant Course Notes* includes information on the legal implications regarding the use of force. The Course Notes state that *'as Youth Workers, there may be times in the course of your employment when you will be required to use force against the young people to effectively carry out your duties*'.[9]

The training package then goes on to state that '*courts have recognised that force may be used as a means of enforcing institutional rules for the discipline and control of young people*'.[10] Without providing further explanation and context to these statements, these may be interpreted as providing a much wider authorisation as to when force is allowed than is actually permitted under the *Youth Justice Regulation 2003.*

[8] Page 42 and page 46 of the Protective Actions, Participant Course Notes.
[9] Youth Detention Centre Training, Protective Actions, Participant Course Notes, p.3.
[10] Youth Detention Centre Training, Protective Actions, Participant Course Notes, p.3.

The training materials also refer to a significant number of legislative provisions, particularly defences available under the *Criminal Code 1899* to youth workers who use force against young people, rather than using the *Youth Justice Regulation 2003* as the most relevant starting point to govern how force is generally used in a detention centre environment.

While the Commission recognises that there are several pieces of legislation which may be relevant to a youth worker role, the explanations of these in the training materials is potentially confusing and may lead to misconceptions about what is authorised in the youth detention context under the Regulation.

For example the training manual deals with situations involving possible death, grievous bodily harm, or riots. Although these types of incidents should be covered and youth detention staff should be provided adequate training on how to respond to these situations, sufficient training also needs to be given for lower level incidents such as young people play fighting/sparring or non-compliance with verbal instructions.

Appropriate training on de-escalation techniques and restraint holds which do not involve the level of force as is used in the current approved techniques may assist in allowing for protection needs to be addressed while also minimising the risk of injury to young people and youth workers.

The Department indicated in its response to the six specific use of force incidents that '*as part of the current Protective Actions training review, all hold techniques are being revisited to ensure their appropriateness within a youth detention setting'.*

The Commission notes that the use of the transport wrist lock technique has been ceased where at all possible at the youth detention centres as per centre directives dated March 2010-CYDC and July 2010 – BYDC. However there has been at least one additional incident where the use of the wrist lock technique was allegedly used since the release of the revised directive11.

Commission Opinion 1: The justifications for the use of force in the legislation are focused on protection rather than merely compliance. This is in contrast to the focus of some of the supporting documents prepared by the Department. It is essential that the information provided on the use of force in the policy and procedure documents and the training materials are an accurate reflection of the legislation.

Provisional Recommendation 1: Within three months the Department review and update policy and procedural documents and training materials referencing use of force to ensure they are an accurate reflection of the relevant legislation. Should any doubt exist, about the legality of these documents or materials, the Commission further recommends that the Department seek legal advice and update the policy and procedural documents and training materials with reference to this legal advice.

[11] Review of detention centre harm reports from July 2010 – July 2011 – Report December 2010

Department's response to Provisional Recommendation 1: The Department accepted the Provisional Recommendation subject to consideration and inclusion of the following advice.

> *A review of the Youth Detention Centre Manual and its related policies (the Review), inclusive of guidance provided in relation to use of force, commenced in November 2011. The Review process includes comprehensive consultation with a Working Group (comprised of key internal stakeholders from a range of youth justice service delivery areas), regular consultation with the Department's legal services, and opportunities for both the Commission and the Inspectorate to review.*
>
> *The relevant chapter of the Youth Detention Centre Manual (Chapter 3: Incident Management) includes the development of a 'Protective Actions Continuum' and a 'dynamic risk assessment framework' that details all intervention options, including the use of force and the risks that must be present for it to be appropriate.*
>
> *The Department will also provide the Commission copies of the approved policies that relate to use of force, once approved by the Director-General. It is expected that the complete Youth Detention Centre Manual will be completed by December 2012.*
>
> *The Department is completing a comparative analysis of Australia's leading protective action training providers and it is anticipated that a training provider will be procured by the end of 2012. Additionally, the Department is revising the competency assessment processes for youth detention centre staff, to reflect the changes currently being progressed as part of the Review.*

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department.

Final Recommendation 1: The Commission recommends that within three months the Department finalise its review and update of policy and procedural documents and training materials referencing use of force to ensure they are an accurate reflection of the relevant legislation. Should any doubt exist, about the legality of these documents or materials, the Commission further recommends that the Department seek legal advice and update the policy and procedural documents and training materials with reference to this legal advice.

Provisional Recommendation 2: The Commission recommends that the Department, in its review of training materials on the use of force (in the next three months), incorporates staff training on the range of situations frontline workers (particularly youth workers and section supervisors) may be faced with and include strategies to deal with uncooperative behaviour prior to escalation.

Department's response to Provisional Recommendation 2: The Department accepted the Provisional Recommendation subject to consideration and inclusion of the following advice.

> *Significant work has been in progress since 2010 to improve the training provided to youth detention centre staff, including:*
>
> - *comparative analysis of protective actions training providers which assessed: national accreditation of the curriculum; modes of delivery and assessment; medically tested techniques, suitability of the techniques for young people; and best practice conflict de-escalation and assault avoidance responses*
> - *assessment of different of modes of delivery*
> - *analysis of dynamic training scenarios that can be conducted safely (including identifying appropriate on-centre and off-site locations)*
> - *analysis of violent incidents that have previously led to injuries and harm to young people and youth detention centre staff, and*
> - *removal of the transport wrist lock technique.*
>
> *As stated above, it is anticipated that a training provider will be procured by the end of 2012.*

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department.

Final Recommendation 2: The Commission recommends that the Department, in its review of training materials on the use of force (in the next three months), incorporates staff training on the range of situations frontline workers (particularly youth workers and section supervisors) may be faced with and include strategies to deal with uncooperative behaviour prior to escalation.

Provisional Recommendation 3: The Commission recommends that staff members (particularly youth workers and section supervisors) be provided with regular training which makes the legislative framework for their duties clear and explains the appropriate circumstances and limits in legislation in relation to the use of force and the oversight mechanisms established to monitor youth detention centres in Queensland.

Department's response to Provisional Recommendation 3: The Department accepted the Provisional Recommendation subject to consideration and inclusion of the following advice.

> *The Department has reached an agreement with the relevant unions through the Queensland Industrial Relations Commission in relation to the issue of regular training and competency assessment. Regular (annual) refresher training in protective actions is currently required for all youth detention centre operational staff. As reported to the Queensland Industrial Relations Commission in early 2012, over 95% of operational staff at both youth detention centres are currently up to date. Staff who are not currently up to date have either been on extended leave or are currently undertaking non-operational duties due to an injury or for other reasons. An improved competency assessment framework is expected to be implemented in the coming six months.*

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department.

Final Recommendation 3: The Commission recommends that staff members (particularly youth workers and section supervisors) be provided with regular training which includes the legislative framework for their duties and explains the appropriate circumstances and limits in legislation in relation to the use of force and the associated oversight mechanisms established to monitor youth detention centres in Queensland.

Provisional Recommendation 4: The Commission recommends that within three months the Department commence work with relevant trade unions or other employee representative groups to confirm knowledge and understanding of the legislative limits on the use of force, and de-escalation techniques to help prevent the use of force, as core competencies for any individuals currently working, or wishing to work, as youth workers or their supervisors within Queensland youth detention centres.

Department's response to Provisional Recommendation 4: The Department accepted the Provisional Recommendation subject to consideration and inclusion of the following advice.

> *The Department has commenced worked [sic] with the relevant unions as part of the action before the Queensland Industrial Relations Commission. The parties have come to an agreed position in relation to the issues raised in provisional recommendation 4. As part of the Review, a 'Protective Actions Continuum' and a 'dynamic risk assessment framework' (see Attachments 2 and 3) have been developed to guide youth detention centre staff in their assessment of risks (and particularly situational and individual factors that may heighten risks) to ensure incidents can be resolved safely using an appropriate and proportionate level of response. The competency assessment framework (as mentioned above) will also ensure that staff understand the legislative framework which governs their practice and are competent in assessing risk and resolving incidents safely and appropriately.*

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department.

Final Recommendation 4: The Commission recommends that the Department continue to work with relevant unions or other employee representative groups to confirm knowledge and understanding of the legislative limits on the use of force, and de-escalation techniques to help prevent the use of force, as core competencies for any individuals currently working, or wishing to work, as youth workers or their supervisors within Queensland youth detention centres.

3. Systemic Issues identified from the six cases

In accordance with the notices of investigation and information issued by the Commission, the Department provided details in relation to six significant instances of harm to young people, as a result of force being used by staff.

3.1 Summary of six young people's cases under this investigation

A summary of each young person's case against the criteria requested in the investigation and information notices has been summarised in tables 3 to 8 outlined below. Theses tables outline the 'protective action' practices used on each of the young people, the currency of training for staff members who were involved in the incident; Department comments, and the resulting outcomes experienced by the young people.

Sections 3.2 – 3.5 of this report which follow the summaries of individual cases, discuss the major systemic issues identified in this investigation. Specific cases are referred to in these sections to highlight some of the key points in this investigation. The Commission recognises that while there may be some limitations to this assessment undertaken by desk-top review, there is still merit in making an assessment of the outcomes for young people, even when these may not accord with the Department's own findings.

Table 3 – Use of force event circumstances - Young Person One

Young Person One	Incident date - 30 March 2010
Rationale for use of force provided by the youth workers	The specific behaviour the young person was exhibiting which was deemed by the officers to be a risk to the child, other persons, or property in the centre and therefore justify the use of force were: "*The Young Person refused to enter his room, was verbally abusive and refused to comply with the escorting staff instructions – creating the immediate potential for other young people to follow suit. Action by staff was within policy requirements to maintain good order and to obtain compliance with a direction."*
Force applied by the youth workers	The specific techniques used by staff were ground stabilisation, transport wrist lock and room insertion, as follows: • A number of verbal instructions were given to the young person to return to their room • Staff were required to ground stabilise the young person to ensure he could be placed in his room safely • When settled, the young person was assisted to stand and taken to the time out room using the transport wrist lock technique • On entry to the time out room, the room insertion technique was applied.

Young Person One	Incident date - 30 March 2010
Department's Comments on the use of force	The Department indicated that '*the staff involved in the incident are considered well experienced with working with young people in youth detention*'[12]. • Youth Worker 1 completed the Protective Actions Course on 14 January 2010 • Youth Worker 2 completed the Protective Actions Course on 17 March 2010 • Youth Worker 3 completed the Protective Actions Course on 19 May 2009. The Department of Communities also noted that '*All young people understand that refusal to return to their room is a serious breach which will result in staff taking immediate action – including the use of approved force if necessary to obtain compliance.*'[13]
Outcome for the Young Person	The young person experienced a dislocated shoulder and fracture to the upper arm.
Commission Comment	There is no evidence that Young Person One's behaviour would have incited other young people as suggested by the Department. There is also no evidence that non-verbal de-escalation techniques were employed in the management of the incident. This is especially noteworthy as there did not appear to be any physical threats made by Young Person One. The force techniques applied (ground stabilised, transport wrist lock technique, and room insertion technique) appear to be an excessive application of force given the offending behaviour of Young Person One as noted in the rationale for the Use of Force. The resulting injuries are evidence in themselves that excessive force was used in the circumstances.

Table 4 – Use of force event circumstances - Young Person Two

Young Person Two	Incident date - 21 September 2009
Rationale for use of force provided by the youth workers	The specific behaviour the young person was exhibiting which was deemed by the officers to be a risk to the child, other persons, or property in the centre and therefore justify the use of force were: "A verbal altercation with another young person which staff attempted to contain through verbal caution and instruction. However this altercation suddenly escalated into physical conflict. While one young person became compliant, Young Person Two continued to attempt to assault him and was struggling violently against staff intervention. Young Person Two's behaviour had the potential to injure the other young person,

[12] Page 3 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.
[13] Page 2 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.

Young Person Two	Incident date - 21 September 2009
	himself or staff. One staff member was injured (scratched by the bolts on the veranda grill[14]) and had to be relieved as he was bleeding profusely"[15].
Force applied by the youth workers	The specific techniques used by staff were ground stabilisation, transport wrist lock and room insertion, as follows: • Staff verbally cautioned Young Person Two who remained uncompliant • Young Person Two was therefore ground stabilised until he was settled • Once settled, Young Person Two was assisted to stand and escorted using the transport wrist lock to separation • On entry to the separation room, the room insertion technique was applied.
Department's Comments on the use of force	The Department indicated that '*the staff involved in the incident are considered well experienced with working with young people in youth detention*'[16]. • Youth Worker 1 completed training on 24 June 2008 • Youth Worker 2 completed training on 4 September 2008. The Department indicated that the staff who applied 'ground stabilisation' when the Young Person Two was transported to Oak 'in this instance attended refresher training'[17]: • Youth Worker 3 completed refresher training on 24 June 2008 • Youth Worker4 completed refresher training on 22 October 2008
Outcome for the Young Person	The young person experienced a fracture to his right wrist.
Commission Comment	Young Person Two was described as being "settled" by staff after being ground stabilised. Despite this staff assessment, Young Person Two was assisted by staff to stand and walk to the separation room under the transport wrist lock before staff utilised the room insertion procedure. The force techniques applied appear to be an excessive application of force given Young Person Two had settled, was not reported to be resisting and a fracture resulted . Information contained in the incident reports also raises concerns in relation to the lack of timely provision of medical attention given to Young Person Two. The resulting injuries are evidence in themselves that excessive force was used in the circumstances.

[14] Incident report IR1 dated 21/09/09 for the event did not indicate that the Young Person directly caused the injury.
[15] Page 4 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.
[16] Page 4 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.
[17] Page 4 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.

Table 5 – Use of force event circumstances - Young Person Three

Young Person Three	Incident date – 14 March 2010
Rationale for use of force provided by the youth workers	The specific behaviour the young person was exhibiting which was deemed by the officers to be a risk to the child, other persons, or property in the centre and therefore justify the use of force were: "Play fighting/sparring with another young person" The Department of Communities later commented that '*This type of behaviour often escalates in a serious physical altercation between the young people, often causing physical injury to one or both young people and to intervening staff, hence the centre's proactive practice of no sparring or play fighting.' The Department of Communities additionally noted that 'cutlery from breakfast was still on the tables where the young people were located, which was a heightened risk to the safety and security of young people and staff.'*[18]
Force applied by the youth workers	The specific techniques used by staff were transport wrist lock and ground stabilisation, as follows: • Both young people were requested to stop sparring, the behaviour continued and escalated into Young Person Three verbally abusing staff. • Staff identified Young Person Three as the instigator of the on-going inappropriate behaviour, staff then directed Young Person Three to move away and sit at a bench. Staff made several verbal directions for both young people to stop the behaviour. • Staff attempted to separate the young people by ushering them away to their bedrooms in an effort to de-escalate their behaviour, as both young persons' behaviour had continued to escalate into verbal abuse. • In this circumstance, staff considered the use of force appropriate.
Department's Comments on the use of force	The Department indicated that the '*staff involved in the incident are considered well experienced with a combined experience of 32 years working with young people in youth detention'*.[19] Youth Worker One, who was 'controlling' the young person's right wrist, had been trained in protective actions and was deemed competent in June 2008. This worker had also completed Non Violence Crisis Intervention Training and handling difficult clients in November 2007. This youth worker was scheduled to attend the refresher Protective Actions training on 23 and 24 August 2010. The Department also stated that the centre '*prioritised the inclusion of Non Violent Crisis Intervention training into the mandatory six week Youth Worker Induction' and that this has occurred since March 2010 and has been well received*'.[20]
Outcome for the Young Person	The young person experienced a fractured right radius (forearm).

[18] Page 6 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.
[19] Page 7 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.
[20] Page 8 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.

Young Person Three	Incident date – 14 March 2010
Commission Comment	Young Person Three was described as "play-fighting" with another young person which rapidly escalated into verbal abuse towards staff. Despite Young Person Three commencing to comply with orders ("*YP Three started to move to where he was directed*"[21]), staff then intervened physically which resulted in force techniques being applied (transport wrist lock technique, room insertion and ground stabilisation techniques). The force techniques applied appear to be an excessive application of force given the initiating offending behaviour (play fighting by Young Person Three) and the risk requisite for the use of force appearing to have passed. The resulting injuries are evidence in themselves that excessive force was used in the circumstances.

Table 6 – Use of force event circumstances - Young Person Four

Young Person Four	Incident date – 21 January 2010
Rationale for use of force provided by the youth workers	The specific behaviour the young person was exhibiting which was deemed by the officers to be a risk to the child, other persons, or property in the centre and therefore justify the use of force were: "Young Person Four and another Young Person were involved in a verbal altercation. Staff immediately intervened and instructed both young people to go to their rooms to settle. The behaviour of the young people had escalated to a point where physical altercation was imminent. Both young people were being verbally aggressive and threatening one another[22]".
Force applied by the youth workers	The specific techniques used by staff prior to force being used on the young person was transport wrist lock, as follows: • Young Person Four was directed on a number of occasions to move away to settle • Staff attempted to separate both young people by using shepherding technique to move them away to their bedrooms so as to settle, this was required as a result of the young people (sic) behaviour continuing to escalate into a potential physical altercation • The other YP was compliant with instruction to attend to his room • Young Person Four appeared to be the aggressor and as a result of him moving toward the other Young Person, staff were required to protect other Young Person and therefore intervened by using transport wrist lock to move Young Person Four to separation
Department's Comments on the use of force	The Department indicated that the staff '*involved in this incident are considered well experienced with a combined experience of 20 years working with young people in youth detention'*.[23] • Youth Worker One, who was 'controlling' the young person's right arm was trained in protective actions and deemed competent in November 2008'.

[21] IR1 7460
[22] Page 8 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.
[23] Page 9 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.

Young Person Four	Incident date – 21 January 2010
	• Youth Worker One had also completed Communicating with Young People (in the same month). • Youth Worker One is scheduled to attend the refresher Protective Actions training on 23 and 2 August 2010.
Outcome for the Young Person	The young person's original diagnosis was a widened radial epiphysis and possible arm/wrist fracture, subsequently treatment given to Young Person Four was as if the arm/wrist was fractured with further treatment to be provided on 29 January at an external clinic. Young Person was released on 27 January 2010 and readmitted on 2 February 2010 with a full cast on his arm. Reportable Incident Report (IR4) identifies that the left wrist was fractured.[24]
Commission Comment	Young Person Four was involved in a verbal altercation with another young person and commenced complying with staff directions to return to their room. Staff intervened by using force via the transport wrist lock to place Young Person Four in separation. The force techniques applied appear to be an excessive application of force given the initiating offending behaviour (verbal taunts of Young Person Four). The resulting injuries are evidence in themselves that excessive force was used in the circumstances.

Table 7 – Use of force event circumstances - Young Person Five

Young Person Five	Incident date – 11 January 2010
Rationale for use of force provided by the youth workers	The specific behaviour the young person was exhibiting which was deemed by the officers to be a risk to the child, other persons, or property in the centre and therefore justify the use of force were: "On 12 January 2010, Young Person Five was found hiding behind buildings. Young Person Five was abusive and non-compliant. Any young person found to be hiding themselves from centre staff is considered a high risk, as it raises issues of concern such as the deliberate hiding of contraband, risk of self-harm taking place or attempting to abscond."
Force applied by the youth workers	The specific techniques used by staff prior to force being used on the young person was transport wrist lock, as follows: • A number of staff made attempts to verbally engage with Young Person Five, Section Supervisor One initiated verbal communication with Young Person Five by asking him to return to the program area. Young Person Five became abusive toward Section Supervisor One. • Youth Worker One assisted by attempting to calm and refocus Young Person Five as his abuse was directed at Section Supervisor One. Youth Worker One made several directions for Young Person Five to return to the program area. However Young Person Five redirected

[24] Incident report IR4 dated 22/01/2010

Young Person Five	Incident date – 11 January 2010
	his abuse toward Youth Worker One • Young Person Five's behaviour required staff to use transport wrist locks to avoid other young people joining Young Person Five.[25]
Department's Comments on the use of force	• Youth Worker One was identified as needing re-training in the whole of the protective action training package. • Youth Worker One completed this training on 21 and 22 April 2010. • Youth Worker One was first trained in Protective Action on 28 May 2009.[26]
Outcome for the Young Person	The young person experienced a fractured right wrist.
Commission Comment	While outside Young Person Five was involved in a verbal altercation with staff and did not comply with staff directions to return to the program area. Staff intervened by applying force using the transport wrist lock to transport Young Person Four over a significant distance to be placed in separation. The force technique applied appears to be an excessive application of force given the age, weight and initiating offending behaviour (hiding from staff). The resulting injuries are evidence in themselves that excessive force was used in the circumstances.

Table 8 – Use of force event circumstances - Young Person Six

Young Person Six	Incident date – 17 November 2010
Rationale for use of force provided by the youth workers	The specific behaviour the young person was exhibiting which was deemed by the officers to be a risk to the child, other persons, or property in the centre and therefore justify the use of force were: "On 17 November, Young Person Six and another young person were involved in a physical altercation following a cup throwing incident by Young Person Six and encouraged by a third young person".
Force applied by the youth workers	Staff attempted to ground stabilised both young people. Young Person Six was not able to be effectively ground stabilised however because of limited space. • Two Youth Workers and one Section Supervisor were then involved in placing Young Person Six in transport wrist locks and escorting Young Person Six to separation and subsequently perform a cell extraction. • Section Supervisor One indicated that "*as soon as he began applying the wrist lock he felt movement in Young Person Six's wrist*"[27].
Department's Comments on the use	Section Supervisor One, in accordance with the Management Action was required to undertake refresher training in Protective Actions.

[25] The information provided by the Department does not indicate what the level of risk of this actually occurring was determined to be.
[26] Page 12 - Department's Response to specific Incidents (Attachment 1) 1 October 2010
[27] Assessment of Allegation Report dated 17/11/2009

of force	Section Supervisor One completed this refresher training on 3 February 2010 and was assessed as competent.[28]
Outcome for the Young Person	Young Person Six experienced a fractured right radius. There is evidence to suggest the follow up treatment may have been compromised due to Young Person Six's inability to understand the use of therapeutic measures[29] given his Autism diagnosis.
Commission Comment	Young Person Six was involved in a minor physical altercation with another young person. There is no indication that staff used any other technique to diffuse the argument/altercation other than force i.e. no verbal warnings appear to have been given to either young people involved. This is particularly significant given staff were aware of the special developmental needs of Young People Six and likely difficulty in understanding the consequences of actions by both staff and other young people. The resulting injuries are evidence in themselves that excessive force was used in the circumstances.

3.2 Systemic issue one - Use of approved techniques by detention centre staff

While the Commission notes that the existing Protective Actions training information specifies that when a '*young person verbally threatens to assault, staff must use appropriate non-physical intervention strategies such as crisis communication skills and negotiation skills to defuse the situation*'[30]. In reality the specific incidents reviewed under this investigation would appear to indicate that 'pain management/compliance' techniques are relied upon more frequently than communication and negotiation skills.

This is further highlighted in the IR4 for Young Person Four which states that the harm was '*allegedly caused during normal course of application of transport wrist lock*'. The Assessment of Allegation form specifies that '*a review of the CCTV images does not suggest any excessive use of force by any staff members involved in the restraining*'.

As such it may be that the 'approved' techniques are being applied as they have been taught to staff but young people are still sustaining serious injuries. Considering the number of injuries sustained by young people the appropriateness of these techniques should be reviewed.

Staff appear to be attempting at least verbal instructions (if not always de-escalation techniques), prior to using force on young people in detention. Certain incidents, particularly the incident involving Young Person Five for example highlights the importance of staff being able to employ techniques to de-escalate a situation wherever possible.

Significantly, it appears that even once young people have settled the 'approved restraint techniques' are still being relied upon to gain further compliance from the young person. For example, the Department's summary of information on the incident involving Young Person One, describes him as being 'settled' (following him being 'ground stabilised') but he was still

[28] Page 13 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.
[29] Page 12 - Department's Response to specific Incidents (Attachment 1) 1 October 2010.
[30] Youth Detention Centre Training, Protective Actions, Participant Course Notes, p.12.

taken to the time out room using the 'transport wrist lock' technique and put into this room using the 'room insertion' technique. Based on the information detailed by the Department in relation to Young Person Two it appears that a similar approach was taken – using the 'transport wrist lock' and the 'room insertion' technique, even once the young person is described as being 'settled', following 'ground stabilisation'. There does not appear to be any kind of physical hold beyond the 'approved techniques' for use once a child has settled (if force is deemed to still be necessary).

Commission Opinion 2: The six incidents highlight the potential problems with the force techniques approved for use on young people in youth detention centres. Based on the information provided, it appears that the 'pain compliance/management' holds are currently the only approved techniques for use in the detention centres[31] and these may not be appropriate for use on young people as evidenced by the resulting injuries.

Provisional Recommendation 5: The Commission recommends that the Department review the suitability of the use of force techniques approved for use on young people in youth detention centres within three months. As part of this review the Commission recommends that advice is obtained from a relevant expert on the safety and appropriateness of the techniques currently approved for use on young people (particularly the techniques involving 'ground stabilisation' of the young people and the use of the 'transport wrist lock'). The Commission also recommends that the Department review the lawfulness of the techniques used, particularly in relation to the 'pain compliance/management' holds and the circumstances under which these techniques could be considered reasonable.

Department's response to Provisional Recommendation 5: The Department accepted the Provisional Recommendation subject to consideration and inclusion of the following advice.

In response to the use of 'ground stabilisation':

- *as part of the work being undertaken to review training (as stated above), the Department has sought medical assessments on the safety of this technique.*

In response to the use of 'transport wrist locks':

- *As acknowledged in the provisional report, staff have been previously advised that the 'transport wrist lock' technique is prohibited. Any use of the 'transport wrist lock' technique by operational staff is treated as suspected misconduct and is referred accordingly.*

In addition, the Department is undertaking a literature and jurisdictional review of the use of pain compliance techniques (including review of the recent coronial inquests into pain compliance techniques in Queensland hospitals). This will inform the final technique list included in the 'Protective Actions Continuum'.

[31] The Department has indicated that the use of hand cuffs has replaced the transport wrist lock technique over long distances. This issue of the use of handcuffs is dealt with in further detail in section 6.1 of this report.

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department

Final Recommendation 5: The Commission recommends that the Department continue its review of the suitability of the use of force techniques approved for use on young people in youth detention centres and finalise within three months. As part of this review the Commission recommends that advice is obtained from a relevant expert on the safety and appropriateness of the techniques currently approved for use on young people. The Commission also recommends that the Department review the lawfulness of the techniques used, particularly in relation to the 'pain compliance/management' holds and the circumstances under which these techniques could be considered reasonable.

3.3 Systemic issue two - Provision of medical care to young people following use of force incidents

The Commission requested information on the incident related to Young Person Two following review of the relevant harm and inspection reports.[32] The discussion of the incident in the inspection report raised concerns about the timeliness and provision of medical attention to Young Person Two (referred to as H in the inspection report) and concerns about the evidence on the video footage differing from the incident reports prepared by detention centre staff.

The incident report states Young Person Two was kicked several times, including in the head[33] during a physical altercation with another young person. An incident report completed by another staff member then states that '*I observed Young Person* (name deleted for de-identification purposes) *punching back window, port hole and door of cell. Young Person later asked for the nurse and complained of sore arm. Nurse examined right arm and immediately organised hospital visit'.*[34]

The inspection report stated that '*video footage obtained by the Inspectorate identifies H being placed on his stomach by the staff conducting the restraint. Footage shows that when staff removed themselves from the cell, H stands up and begins to nurse his right arm. Footage also shows H, on at least three separate occasions pressing the button on the intercom system to alert staff*'. The inspection report also stated that '*video footage ascertains that section staff did not physically attend to H until forty three minutes after he was initially placed in the cell. After speaking to H a staff member leaves the cell and then returns to administered (sic) first aid in the form of a cold pack to H's injured right arm. The*

[32] The inspection report detailed a de-identified use of force incident, in which the young person was referred to as 'H'. The information provided by the Department states that the matter referred to in the Inspection Report Queensland Youth Detention Centres September quarter 2009 is the same as incident IR4 761/09. That is, the incident in the inspection report which refers to the young person as 'H' is the incident involving Young Person Two.

[33] Incident IR1 dated 21/09/2009

[34] Incident IR1 dated 21/09/2009

footage also shows that the Clinical Nurse attended to H one hour and sixteen minutes after he was placed in the cell'.[35]

An inspection report prepared under Section 263 of the *Youth Justice Act 1992* also stated that '*Two staff involved in the incident submitted a separate incident report at 12:10pm stating they observed H hitting the door and walls with his hand while he was separated in the holding cell. This report was written one hour and sixteen minutes after it was identified by the Clinical Nurse that H had an injured wrist. There is no evidence on the video footage showing H hit the wall or door with his right hand/arm. Young person H formally complained to a staff member that he had made several attempts to alert staff that he was injured. H also made a complaint that staff stated to him that he hurt his arm because he was banging on the door/window with it*'.[36]

The IR4 provided by the Department records under the heading 'name (and position where relevant) of the person/s reasonably suspected of causing the harm: *'unknown – possible of Self Inflicted Injuries'*.[37] This incident raises serious issues in terms of how the provision of medical attention following an incident is managed and how the Department manages its review of staff reports when they are inconsistent with video footage and/or Young Person's complaints[38]. Firstly, the incident report on the altercation between the two young people indicated that Young Person Two received kicks to the head.[39] This type of head trauma should be provided with immediate medical attention and observation.

Secondly, mandating the offering of medical assessment following the use of force would also assist any subsequent processes that might require the veracity of staff statements to be tested. If medical attention had been provided immediately after this incident then an injury may have been identified and treated, enabling an account of the injury to be independently recorded.

Commission Opinion 3: The six incidents highlight the potential for injury to young people as a result of the use of force by officers, such that the offering of medical assessments following such events should be mandated.

Provisional Recommendation 6: The Commission recommends within the next three months that the Department state in policy and procedures that medical assessment is to be offered promptly to young people who are involved in a serious physical altercation with another person or when force is used on a young person by a staff member.

[35] Inspection Report September quarter 2009, Page 28
[36] Inspection Report September quarter 2009, page 27-28
[37] Incident IR1 dated 21/09/2009
[38] Statement concerning YP Two by Youth worker to Manager Monitoring and Compliance.
[39] Incident IR1 dated 21/09/2009

Department's response to Provisional Recommendation 6: The Department accepted the Provisional Recommendation subject to consideration and inclusion of the following advice.

> *The relevant policy and practice documentation already requires medical assessment and treatment following an incident and the Detention Centre Operational Information System (DCOIS) records comprehensive details of this service delivery. Any staff member who acts to prevent a young person from accessing medical assessment and treatment, will be referred to Ethical Standards for investigation.*

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department.

Final Recommendation 6: The Commission recommends within the next three months that the Department state in policy and procedures that medical assessment is to be offered promptly to young people who are involved in a serious physical altercation with another person or when force is used on a young person by a staff member.

Provisional Recommendation 7: The Commission recommends that the Department provide the Commission with further advice as to the investigations undertaken into the incidents involving the six young people, including:

- the outcomes of the investigations and any actions taken by the Department as a result, and
- advice as to how the Department kept the young people informed of the investigations' progress and outcomes, regardless of whether they were in detention at the time of completion.

Department's response to Provisional Recommendation 7: The Department accepted the recommendation in principle on the proviso it is amended to reflect the following information.

> *The matters referred to in the report have been assessed and investigated as required by Ethical Standards and the relevant youth detention centre (with oversight of the former Assistant Director-General, Statewide Services), and are now all closed. The Department made all possible efforts to keep the relevant young people informed of these matters. In addition, it is a standard part of the investigation and assessment process that Ethical Standards and relevant youth detention centre staff would liaise with the young person's Youth Justice Service Centre caseworker in relation to any complaints and investigation matter if the young person had been released from detention before its finalisation.*

However, the Department acknowledges that the policy and practice guidance concerning how young people are kept informed as part of a complaints or investigations needs to be strengthened, and this will done as part of the Review. It is expected that the complete Youth Detention Centre Manual will be completed by December 2012.

The Department would also like the Commission to reflect in its report that an assessment of whether use of force was appropriate and reasonable may not be suitable for desk-top review only. For example, in relation to Young Person One, the Commission states on page 18 that "The resulting injuries are evidence in themselves that excessive force was used in the circumstances." The Department's Ethical Standards Unit assessed this incident and their investigation found the matter to be unsubstantiated. The Department would also like to reiterate that any suspicion or allegation of staff misconduct is referred immediately by detention centre management to the Ethical Standards Unit.

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department.

Final Recommendation 7: The Commission recommends that the Department provide the Commission with further advice as to the investigations undertaken into the incidents involving the six young people, including:

- the outcomes of each of the investigations and any actions taken by the Department as a result, and
- advice as to how the Department kept the young people informed of the investigations' progress and outcomes, regardless of whether they were in detention at the time of completion.

3.4 Systemic issue three - Proportionate Use of Force

Included in the materials provided by the Department in relation to the incident involving Young Person Five was a statement from the Clinical Nurse.

The Clinical Nurse stated that he had witnessed two staff members restraining the young person. The nurse's statement in relation to Young Person Five included discussion of some factors that '*influence a fracture while stabilising someone. Some of these issues in this incident were, the young person's bone strength, which is influenced by many factors including the mothers health while carrying, his nutrition status when an infant up until*

present, whether he had had an underlying weakness in his arm before this incident caused by trauma or disease'.[40]

The Clinical Nurse's statement also said that there are '*some other issues that would have assisted in causing this injury. The height of the youth workers applying the wrist lock. This young person's height is 148cm and his weight is 28.9kgs. Both staff members were much taller than this young person*'[41] and presumably also much heavier. This information in relation to this particular young person highlights the importance of taking their size into account when determining the level of force to be applied, in situations when force has been deemed necessary. This is a particularly relevant consideration when these events generally appear to involve at least two staff members applying the 'use of force' techniques on the one young person, who in this case weighed 28kg.

The techniques used on Young Person Three (who sustained a fractured right radius) were the transport wrist lock and ground stabilisation. If training such as 'Non Violence Crisis Intervention Training' is not clearly prioritised over the use of 'pain management' or 'pain compliance' techniques then it is open to workers to use techniques involving force in situations where such a response is disproportionate to the circumstances and risk present.

Incidents at the lower end of the risk scale (such as children play fighting or hiding behind a building) may require force to be used if it is deemed that the circumstances under the Regulation do exist. However, it is questionable whether the minimum amount of force is actually always being used to manage the situations. Considering the number of injuries to young people and the seriousness of these injuries, it appears that the amount of force being used in some circumstances is excessive. It is questionable that the characteristics of the child and the risk of incident escalation are always taken into account as demonstrated in the case of Young Person Five (weight 28.9kg and height 148cm)[42] who was hiding behind a building verbally taunting staff, which resulted in a two person transport wrist lock restraint application with a third youth worker providing support during the escort and room insertion to separation.

Additionally, the summary of the incident involving Young Person Five stated that '*Any young person found to be hiding themselves from centre staff is considered a high risk, as it raises issues of concern such as the deliberate hiding of contraband, risk of self harm taking place or attempting to abscond'*. However there is no indication in the materials that any of these risks were present in this particular situation. A blanket Policy on the use of force in such circumstances is inappropriate.

It is also worth noting that the Incident Report (IR1) has a section for staff to complete with the heading 'Why did the incident occur?'. Although this section does not ask for the specific justification for force being used the answers of the staff members involved were generally that Young Person Five was non compliant with staff directions, not following staff directions, abusive towards staff when asked to follow directions.[43]

[40] Statement of Clinical Nurse, 13/01/2010.
[41] Statement of Clinical Nurse, 13/01/2010.
[42] Statement of Clinical Nurse, 13/01/2010.
[43] As reported by staff in IR1 7262 dated 11/01/2009 (four IR1s were completed by staff members in relation to this incident).

Similarly, little consideration appears to be given to young people who may have impaired cognitive function or low level impairment which may impact their ability to comprehend instructions and/or cause them to become more physically agitated than otherwise expected. For example, Young Person Six had a diagnosis of Autism and staff where made aware on his admission to detention that expectations would need to be explained to him a number of times in plain simple language and that he would have difficulties coping with noisy and disordered environments and changes to routines[44]. These special needs do not however appear to have been considered due to the absence of any verbal de-escalation and ultimately the physical techniques used by staff to restrain him. Young Person Six's ability to understand the events and consequences and control his own behaviour within a volatile situation would be vastly different to other youth.

This is an important consideration when determining whether the force being used is reasonable as specified section 17(5) of the Regulation. The Operational Procedure – Safety and security – incident response (YDC-034-02) specifies that the '*degree of physical intervention used in approved restraint procedures will be determined by an assessment of factors that include but are not limited to the following:*

- *the nature of the misbehaviour*
- *the young person's age and maturity*
- *the physical stature of the young person*
- *the physical stature of the staff member 'using force'*[45].

After force has been used on a young person the training package specifies that the incident must be reported. This is positive and reflective of the provisions of the Regulation. However, there does not appear to be a process for a 'de-brief' to occur with the particular young person and staff members involved in the incident. This type of process would be distinct from the complaints and procedures process and would rather be a process to discuss the behaviours that lead up to force being deemed necessary and explaining these to the young person involved. The Commission recognises that this may occur in practice however incorporating this into the training package may assist in highlighting the importance of this as part of the overall behaviour development and behaviour management of the young person involved.

Commission Opinion 4: Even if the use of force was lawful and justified in the six incidents, the injuries sustained by the young people indicate that the amount of force used was disproportionate to the risk presented in some of the circumstances. Significant differences in size, weight and strength exist between some young people and youth workers, which are relevant to the use of force, but do not appear to have been adequately considered by the officers.

[44] Email from case worker to all relevant Detention Centre youth workers and section supervisors regarding Young Person Six's special needs while in detention in regard to his Autism diagnosis dated 13/11/2009

[45] Operational Procedure – Safety and security – incident response (YDC-034-02), p.2.

Provisional Recommendation 8: The review of the approved techniques under the staff training take into consideration:

- the various factors raised by each of the incidents under this investigation, including the behaviours exhibited by the young people prior to the use of force
- whether or not these actions justified the use of force (under the provisions of the Regulation and Department's associated policies and procedures)
- the specific technique and amount of force used in applying this technique
- consideration of the specific physical characteristics or disability of the young person in determining what (if any) level of force to apply in a situation, and
- how staff should undertake the debriefing of a situation with a young person following the use of force on that young person.

Department's response to Provisional Recommendation 8: The Department accepted the Provisional Recommendation subject to consideration and inclusion of the following advice.

As part of the Review and assessment of training options, the Department has already considered these issues. As stated above:

- *as part of the Review, a 'Protective Actions Continuum' and a 'dynamic risk assessment framework' have been developed to guide youth detention centre staff in their assessment of risks (and particularly situational and individual factors that may heighten risks) to ensure incidents can be resolved safely using an appropriate and proportionate level of response.*
- *the Department has conducted an analysis of violent incidents that have previously led to injuries and harm to young people and youth detention centre staff to inform the development of the Protective Actions Continuum' and a 'dynamic risk assessment framework', and*
- *the competency assessment framework will also ensure that staff understand the legislative framework which governs their practice and are competent in assessing risk and resolving incidents safely and appropriately.*

The Commission will be provided copies of the relevant policy and practice documents by mid August 2012, including:

Chapter 3: Incident Management

- *Policy: Creating a safe and supported working environment*
- *Policy: The Department's duty of care obligations*
- *Policy: Duty of care considerations for youth detention centre staff involved in violent or potentially violent incidents*
- *Policy: Youth Detention Protective Actions Continuum*
- *Policy: Responding to an incident without assistance*
- *Policy: Use of mechanical restraints in youth detention centres*
- *Policy: Responding to an incident involving a dangerous item*
- *Policy: Use of separation as a post incident action*

- *Policy: Suspected misconduct and official misconduct process, and*
- *Policy: Identifying and reporting harm in youth detention.*

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department.

Final Recommendation 8: The Commission recommends that the review of the approved techniques under the staff training take into consideration:

- the various factors raised by each of the incidents under this investigation, including the behaviours exhibited by the young people prior to the use of force
- whether or not these actions justified the use of force (under the provisions of the Regulation and Department's associated policies and procedures)
- the specific technique and amount of force used in applying this technique
- consideration of the specific physical characteristics or disability of the young person in determining what (if any) level of force to apply in a situation, and
- how staff should undertake the debriefing of a situation with a young person following the use of force on that young person.

3.5 Systemic issue four - Directives to authorise the use of handcuffs

A March 2010 Centre Directive acknowledges that one centre has experienced an increase in the number of young people who have sustained an injury caused by the use of force.

The Directive states that handcuffs are to be used in place of transport wristlocks *'when young people are required to be transported to a separation room under force outside of the accommodation units. The use of transport wristlocks within the accommodation units should still be utilised as per current practise (short distance), however handcuffs maybe used within the accommodation units at the discretion of the approved delegated officer'*.[46]

There is also a July 2010 Centre Directive[47] stating that handcuffs are to be used rather than the transport wrist lock technique, regardless of the distance young people need to be moved under restraint. The Regulation places strict restrictions on the use of restraints in Division 4 section 19-21 as paraphrased below.

Section 19 — *The chief executive may approve types of restraints (approved restraints) a staff member may use to restrain a child in the chief executive's custody.*

Section 20(1) — *The chief executive may authorise a staff member to use approved restraints to restrain a child in the chief executive's custody*".

[46] Centre Directive, March 2010
[47] Centre Directive, July 2010

Section 20(2) *The staff member authorised by the chief executive to use restraints may only use these in the detention centre if the chief executive considers, on reasonable grounds, that – (b)(i) it is reasonably likely that the child will attempt to escape, or (ii) the child could seriously harm himself, herself or someone else or (iii) the child could seriously disrupt order and security at the detention centre".*

Section 20(3) *However a staff member must not use approved restraints under subsection (2)(b) unless the chief executive considers on reasonable grounds there is no other way to stop the child –*

(a) attempting to escape; or

(b) seriously harming himself, herself or someone else; or

(c) seriously disrupting order and security at the detention centre.

Section 20(4) *If approved restraints are used on a child then the child Executive Officer must ensure –*

(a) all reasonable steps are taken to use the restraints in a way that respects the child's dignity; and

(b) the restraints are used for no longer than is reasonable necessary in the circumstances.

Commission Opinion 5: While restraints such as handcuffs may be required in certain circumstances, these circumstances are limited, as outlined in the provisions of the Youth Justice Regulation 2003. Utilising handcuffs as the sole replacement to the 'transport wrist lock technique' therefore requires detailed consideration in policy, procedural and training contexts.

Provisional Recommendation 9: The Commission recommends that the inspections required under section 263 of the *Youth Justice Act 1992* periodically, review the use of restraints (including handcuffs) across both detention centres to confirm the information provided to staff on their use and current practice aligns with the provisions of the *Youth Justice Regulation 2003*.

Department's response to Provisional Recommendation 9: The Department accepted the Provisional Recommendation subject to consideration and inclusion of the following advice

The Youth Detention Inspectorate routinely monitors the use of restraints. To assist in this process, the Inspectors have access to the Detention Centre Operational Information System (DCOIS) to facilitate contemporaneous monitoring of the use of restraints to ensure compliance with sections 20 and 21 of the Youth Justice Regulation 2003. In addition, since January 2011, the Inspectorate has made 11 recommendations regarding the use of restraints; all of which have either been implemented or are in the process of being implemented (that is, for recommendations regarding the Review and training).

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department.

Final Recommendation 9: The Commission recommends that the inspections (under section 263 of the *Youth Justice Act 1992)* periodically review the use of restraints (including handcuffs) across both detention centres to confirm the information provided to staff on their use and current practice aligns with the provisions of the *Youth Justice Regulation 2003*.

3.6 Systemic issue five - Complaints management and investigation following use of force incidents

3.5.1 Harm reporting

Section 268 of the *Youth Justice Act 1992* requires detention centre staff who become aware of or suspect a child has suffered harm while detained must report the Harm to the Chief Executive. Division 10 of the Regulation, prescribes the approach that the Department must take in keeping records and reporting on all harm or suspected harm

Under section 37 of the Regulation, reports of harm and suspected harm in youth detention centres must be provided to the Commission by the Department on a monthly basis for monitoring and review.

All six incidences of harm were reported under the Harm reports and two instances were also reported by the Young People concerned to the Commission's Community Visitors during one of their standard visits.

3.5.2. Young People offered a chance to complain

The Department provided the Commission with the YDC-010-01 Complaints policy and procedure as well as some details in relation to the complaints and investigation processes involving the six specific young people. Information on the complaints management and investigation processes provided by the Department for each of the six young people is summarised at Attachment B.

The Department's Operational Procedure in relation to complaints management includes a section regarding complaints following '*an incident/event generating a Reportable Incident Report*'. The Procedure document specifies that "*young people must be provided with an opportunity to make a complaint to the centre, Queensland Police Service (QPS) or both after an incident or event in the youth detention centre, including after they have been:*

- *involved in altercations with other young people*
- *subject to an incident response (i.e. use of force and/or a restraint)*

Two staff members who were not involved in the incident must ask the young person if they wish to make a complaint.[48]

Documents provided by the Department indicate that centre staff completed a *Police/CMC Register of Complaint (IR3) Form* with each of the young people concerned. Each form lists two staff members (who were not involved in the harm incident) as asking the young people involved if they wished to make a complaint to either the QPS or to the centre.

3.5.3 Referrals to other entities

All cases were referred to the Department's Youth Detention Operations and Ethical Standards Unit for review. Of the six cases, Young Person One, Young Person Two and Young Person Three indicated they wanted to make a complaint to the QPS, Young Person Two also made a complaint against the centre. From the documents provided to the Commission it is evident that the Department referred a further two cases (Young Person One and Young Person Six) to the Crime and Misconduct Commission (CMC). Young Person Two's case was also referred to the Queensland Ombudsman's Office, which stopped its investigation when it realised other entities were also investigating the case.

Given the documents were provided at a point in time, the Commission recognises that the Chief Executive may have referred additional cases to QPS or CMC for further investigation. The outcomes of any investigations by QPS and CMC are unknown as none were finalised when the Commission sought documents to support this investigation.

While there is evidence that staff were working to adhere with the complaints procedure, it appears that in the case of Young Person Six, who is diagnosed Autistic, this may not have been sufficient given his comprehension and special needs. Staff were made aware prior to Young Person Six's admission to the centre of his diagnosis and the Department stated that strategies were developed for staff to manage Young Person Six's behaviour. However Young Person Six's low cognitive functioning and requirement to have expectations explained to him a number of times in plain simple language, as recognised by the Department at admission, does not appear to have been taken into consideration when dealing with the complaints process, or if this did occur it was not documented.

3.5.4 Outcome advice to young people

There appears to be some inconsistencies in how complaints are managed by each of the centres including in relation to how young people and their care givers are advised and kept informed of complaints and investigation processes both during their detention and upon release.

The incident involving Young Person Three highlights additional issues in this regard, most particularly when a complaint is made by a person external to the detention centre and how this is managed by Department staff under the existing complaints and investigation procedures.

The complaints procedure specifies that that '*when parents, carers or persons external to the centre express concern about staff or service provided by staff in a youth detention centre and in the community they should be encouraged to address their concerns by contacting the*

[48] Page 8 Operational Procedure Assessing Services – Complaints Management YDC-010-01.

Centre Director/Deputy Director, in person, over the telephone, by electronic mail, fax or in writing. Complaints may also be lodged verbally with any staff member. All complaints made by an external person are to be recorded on the form COM2 Complaints made by an external person to a youth detention centre and forwarded to the Manager, Monitoring and Compliance. [49]

Records provided by the Department indicated that the care provider for Young Person Three had raised concerns with detention centre staff in relation to the incident and the injury he had sustained.[50] The information provided appears to indicate some confusion in relation to the handling of complaint matters by detention centre staff.

While it may be very beneficial for a young person's case worker to maintain contact with the young person[51] and their family in relation to the incident, the concerns raised by the young person's care giver in relation to the incident is required by the Department's Policies and Procedures to be managed by the Manager of Monitoring and Compliance and the Deputy Director of the Detention Centre.

It is not clear from the information provided by the Department how the complaint process was managed with Young Person Three's care-giver. The information provided by the Department did not indicate whether Young Person Three's care-giver had been provided with (at minimum) monthly update on the progress of the investigation.[52]

3.5.5 Establishing a Complaints Management Process

Outside the auspices of this Investigation the Commission has been advised by the Department that work is progressing on a new Complaints and Incident Management Standard to be implemented and operational throughout Queensland Youth Detention Centres by 2012[53]. The Commission is very supportive of the work being progressed and has written separately to the Department detailing a range of issues that require consideration including but not limited to issues already identified through this Investigation process. This particularly relates to transparency, independence and confidentiality of the current complaints and subsequent investigations processes.

Commission Opinion 6: The incident documents of the six young people examined under this investigation highlight the importance of an accountable and transparent complaints management system for both young people and people acting on their behalf such as care-givers and relatives.

Provisional Recommendation 10: The Department confirm within three months that its Complaints and Incident Management Standard and associated operational procedures and staff training, detail a clear incident referral process to internal accountability mechanisms (such as the Department's Ethical Standards Unit) and external entities (such as QPS).

[49] Operational Procedure, Accessing Services – complaints management, YDC-010-01, p.10.
[50] Email dated 14 March 2010
[51] As indicated in emails dated 15 March 2010.
[52] As required by Operational Procedure, Accessing Services – complaints management, YDC-010-01, p.11.
[53] Meeting on 25 November 2011 between Commission staff and officers from your Youth Detention Operations

Department's response to Provisional Recommendation 10: The Department accepted the Provisional Recommendation subject to consideration and inclusion of the following advice.

> *The existing policy and practice documentation make this clear. As part of the Review, these processes will be strengthened and will include a dedicated policy relating to external complaint mechanisms available to young people in youth detention and the Department's commitment to facilitating young people's access to these. As part of this work, the Department has consulted with the Office of the Queensland Ombudsman to inform these drafts. The Commission will be provided an opportunity to comment on this work in the coming months.*

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department.

Final Recommendation 10: The Commission recommends that the Department confirm within three months that its revised complaints and incident management policy, procedures and training materials, detail a clear incident referral process to internal accountability mechanisms (such as the Department's Ethical Standards Unit) and external entities (such as the Commission, the Queensland Ombudsman and CMC).

Provisional Recommendation 11: The Department confirm within three months that internal accountability mechanisms exist to ensure complaints raised by young people with the Department are acted on in a timely manner and that complainants are updated at a minimum of a monthly basis of the progress of the matter.

Department's response to Provisional Recommendation 11: The Department accepted the Provisional Recommendation subject to consideration and inclusion of the following advice.

> *Pre-machinery of government changes, the Department's Ethical Standards Unit provided oversight to the complaints system available to young people. The Department was also in the process of implementing Resolve across both youth detention centres to improve transparency of the process and reporting capacity. As part of the transition arrangements, new processes and information system arrangements are still being established.*
>
> *In addition, the Department conducts regular monitoring of post-incident actions to ensure that young people are provided with an opportunity to make a complaint, in accordance with the existing policies and procedures. It also remains committed to ensuring young people's access to Commission Community Visitors and continually exploring ways to strengthen these relationships (for example: Cleveland Youth*

Detention Centre allows the local Community Visitors to conduct their team meetings at the centre).

However, ensuring that young people in youth detention have access to a robust, transparent and responsive complaints system is a high priority for the Department and I acknowledge the Commission's ongoing advocacy in relation to this area. As previously advised, the complaints management mechanisms available to young people are being reviewed as part of the policy and Youth Detention Centre Manual review. This work is expected to be completed by December 2012. The Department has also met with the Office of the Queensland Ombudsman to discuss the proposed changes to the complaints management framework.

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department.

Final Recommendation 11: The Commission recommends that the Department confirm within three months that internal accountability mechanisms exist to ensure complaints raised by young people with the Department are acted on in a timely manner and that complainants are updated at a minimum of a monthly basis of the progress of the matter.

Provisional Recommendation 12: That the Department consider the analysis, findings and recommendations contained in this Investigation report and Recommendation 15 from the Forde Inquiry, and confirm its Complaints and Incident Management Standard and associated operational procedures and staff training are appropriately aligned and "child friendly".

Department's response to Provisional Recommendation 12: This recommendation is accepted in principle on the proviso it is amended to reflect the following information.

As stated in the response above, the Department will ensure that the revised complaints management system available to young people in youth detention will reflect current best practice. In relation to 'child-friendly' versions, the Department has young-person friendly versions of complaints information, as well as 'family-friendly' versions.

The Department is currently in the process of updating the 'young-person' and 'family-friendly' communication materials to reflect the recent machinery of government changes and the revised complaints management framework (once approved by the Director-General).

The Commission acknowledges the Department's acceptance of the recommendation and action to date. Based on this advice the provisional recommendation has been confirmed as final under s.50(1) of the Commission's Act. The extent to which the action taken achieves compliance with the recommendation will be assessed in three months, based upon further evidence to be provided by the Department.

Final Recommendation 12: The Commission recommends that the Department consider the analysis, findings and recommendations contained in this Investigation report and Recommendation 15 from the Forde Inquiry, and confirm its revised Complaints and Incident Management policies and associated operational procedures and staff training are appropriately aligned and "young person friendly".

Attachment A:

Protective Actions – Approved Restraint Techniques

Type of Restraint	Force Category	Purpose	When Used	Expected Effects	Medical	Procedure
Transport Wrist Lock	Soft empty hand control	A method of controlling an unco-operative person through the principles of pain compliance	When a person resists by bending their elbow and pulling the forearm away. Pressure is applied to the wrist joint.	Immobilisation of the affected arm. Medium to high levels of pain.	Correct use: No medical complications (be aware of pre-existing injuries and developing bones structures) Excessive use: Stretching of the extensor tendon. Possible rupture of the extensor mechanism of the hand.	Commence with your hands in the V grip position on the young person's arm. Slide your right forearm inside the young person's elbow and use this arm to pull the young person toward you, displacing his/her balance. As the young person's elbow stops against your ribs, begin compressing his/her wrist by bending it at the fist, bending the palm toward the inner forearm. While stabilising the young person's elbow between your forearm and side place your right hand on top of your left hand and compress the young person's wrist downward until compliance is achieved. Continue to give loud, clear commands to the young person. Once the young person complies pressure **must** be eased but the wrist-lock maintained.[54]
Straight Arm Bar	Soft empty hand control	A method of controlling an uncooperative young person using the principles of pain compliance and decentralisation.	When the young person is pushing or pulling away presenting their arm locked out in resistance. Pressure is applied to the elbow and	Young person is controlled through immobilisation of the affected arm.	Correct use: No medical complications Excessive use: Disruption of the shoulder's rotator cuff	Commencing in the escort position, pull the young person's left arm across your body towards your left hip, decentralising his/her balance. Slide your right forearm to the rear of the young person's lower triceps. This action hyper-extends the young person's elbow and shoulder joint. Use your body weight and the 'bony blade' of your forearm, as you push downwards towards the ground. Step forward and widen your stance to maintain hyperextension, of the young person's elbow and shoulder joint.

[54] Page 20-21 of the Protective Actions – Induction Training Package, provided by the Department to the Commission on 1 September 2010.

Type of Restraint	Force Category	Purpose	When Used	Expected Effects	Medical	Procedure
			shoulder joint.			Upon grounding the young person, maintain grip to their bent wrist and drop your knee closest to them onto the ground, securing close into the body. Continue to give clear loud commands, any resistance, resume pain by applying pressure at the wrist and triceps. Upon compliance ease the pressure but don't release the grip.[55]
Reverse Wrist Lock	Soft empty hand control	A method of controlling an uncooperative person through the principles of pain compliance.	When the person's hand is near their side and staff can approach from the escort position. Pressure is applied to the wrist joint.	Expected effects: Immobilisation of the affected arm. Medium to high levels of pain.	Correct Use: No Medical complications Excessive Use: Stretching of the extensor tendon. Possible rupture of the extensor mechanism of the hand.	When approaching from the escort position use your outside hand to grasp the back of the young persons hand whilst your thumb wraps around the lower part of their thumb. Simultaneously step through with or (sic) other arm going between their arm and body. As the arm goes through, turn their wrist until the palm is turned skyward. Lift captured hand up until the arm has a 90 degree bend. Secure the young person's wrist with both hands, whilst keeping their arm locked at 90 degrees in such a way that the arm is secured. The escort is immediately commenced and verbal directions are given. Where possible, re-adjust your hands so that the hand furthermost from the young person is on top and therefore able to defend against any attack from the non-controlled arm, to open doors etc.[56]
Two Person Take Down	Soft empty hand control	This is the same method as a Straight Arm Bar with an officer securing each arm.				Both officer's are coordinating between themselves to ensure the young person is ground stabilised effectively. For safety reasons a third person will secure the shoulders when going to ground, to eliminate any possible injuries during practice.[57]

[55] Page 22 of the Protective Actions – Induction Training Package, provided by the Department to the Commission on 1 September 2010.
[56] Page 22-23 of the Protective Actions – Induction Training Package, provided by the Department to the Commission on 1 September 2010.
[57] Page 23 of the Protective Actions – Induction Training Package, provided by the Department to the Commission on 1 September 2010.

Type of Restraint	Force Category	Purpose	When Used	Expected Effects	Medical	Procedure
Three Person Room Removal		Room removal of an individual is usually performed by a primary team of three Youth Workers/staff, with other Youth Worker providing back-up as necessary.			Note: Positional Asphyxia can occur when body position interferes with respiration. This occurs where a person is severely restrained. The person will become inactive after several minutes, exhibit respiratory difficulties and stop breathing.[58]	The central Youth Worked/Staff of this three-person team should take command. He/she is to give instructions to his/her assisting Youth Workers/staff and also to the young person. This avoids any uncertainty by the young person receiving conflicting directions. The central Youth Worker/staff of this team is referred to as Number 1, the assisting youth workers become number 2, and 3 respectively. Number 1 Youth Worker, communicates with young person to cease his behaviour or force will be used to relocate to another area (104-4/5.7) Whilst this is performed youth worker 1 is observing young persons body language and any possible weapons, or obstacles (wet floor, shampoo etc) which may impede the teams performance. Using a soft restraint pad, the team positions themselves in a triangle formation with number 1 in front securing the pad, number 2 and 3 directly behind number 1. As the team enters the room approaching the young person, number 1 secures the young person against the wall with the soft pad. Number's 2 and 3 peel off from behind number 1 to secure both arms. A two person take down procedure is performed at this point with number 1 youth worker supporting the shoulders after discarding the soft shield. The young person is transferred from wall to floor. Number 1 youth worker instructs youth workers 2 and 3 to secure young persons arms behind the back while maintaining a wrist lock. Number 1 youth worker is communicating with young person and assessing his/her condition. (refer – note potential asphyxia).

[58] Page 24-25 of the Protective Actions – Induction Training Package, provided by the Department to the Commission on 1 September 2010.

Type of Restraint	Force Category	Purpose	When Used	Expected Effects	Medical	Procedure
						Numbers 2 and 3 move into transfer position this is achieved by threading one arm from under the shoulder through to the wrist lock at the back. Number 1 proceeds to place both hands on young person shoulders and with clear directions instructs the young person to come to their knees which number 1 is assisting the young person by pushing backwards. (note: youth workers 2 and 3 are not to apply any lifting pressure to young persons shoulders). (At this point number 1 has an option to transport young person in this position with hands at the back or as follows.) Number 1 instructs number's 2 and 3 to transfer their holds into transport wrist locks. Once this is complete and young person is secure. Number 1 instructs young person to rise to his/her feet and keep knees bent. If young person is prone to spotting, number 1 maintains head control (one hand on back of head chin to chest).
Three person room insertion					Note: Positional Asphyxia can occur when body position interferes with respiration. This occurs where a person is severely restrained. The person will become inactive after several minutes, exhibit respiratory difficulties and stop breathing.[59]	Number 1 instructs young person to get down on his/her knees. Numbers 2 and 3 change their holds from transport wrist lock to straight arm bar and proceed to place young person on the ground with Number 1 supporting shoulders. (number 1 ensures young person's head doesn't connect with the ground) Number 1 young worker instructs youth workers 2 and 3 to secure young person's arms behind the back while maintaining a wrist lock. Number 1 youth worker is communicating with young person and assessing his/her condition (refer – note positional asphyxia) Number 1 instructs the young person to lift a leg up and cross it over to the other leg. Young person is then instructed to raise that leg. Number 2 or 3 secures the

[59] Page 24-25 of the Protective Actions – Induction Training Package, provided by the Department to the Commission on 1 September 2010.

Type of Restraint	Force Category	Purpose	When Used	Expected Effects	Medical	Procedure
						leg by grabbing the foot closest to them. Number one going around and secures legs. Number 1 secures each wrist lock behind the young person's back and instructs number 2 to secure the belt of number 1. Number 3 is instructed to secure the door on evacuation of staff from room. Number 1 gives the command "out" or counts 1, 2, 3 and both numbers 1 and 2 exit room with number 3 securing door after them.[60]

The Department provided details in relation to the incidents involving particular young people. This Attachment also provides a brief outline of the types of 'hold techniques'[61] used in the incidents. This information presents the various techniques in a slightly different way to the wording in the training package. This information is summarised below -

Ground Stabilisation: This is an approved technique used to bring a Young Person (YP) back under control by softly placing the YP face down on the floor and holding him/her in this position until he/she is settled.

Transport Wrist Lock: This is an approved technique which involves staff on either side of the YP each holding a hand bent at an angle with downwards pressure. Correctly applied, this hold does not cause pain unless the YP suddenly becomes resistant. Attachment 1 provided by the Department states that 'transport wrist locks when used appropriately are not used as a means of pain compliance'[62]

Straight Arm Bar: This is an approved technique which involves staff on either side of the YP each holding the wrist and elbow with downwards pressure. Correctly applied, this hold does not cause pain unless the YP suddenly becomes resistant.

Room insertion: This is an approved technique designed to place a resistant YP into a separation room in a manner which does not permit him to lash out, spit on, or otherwise assault staff. It is essentially a ground stabilisation process with an additional exit manoeuvre.

Although attachment 1 states that the transport wrist lock and the straight arm bar technique do not cause pain 'unless the young person suddenly becomes resistant' the Training Package seems to indicate that that the purpose of the techniques are focused on 'pain compliance' and the stated expected effects of the transport wrist lock are . The training package outlines that the expected effects of the transport wrist lock, straight arm bar and reverse wrist lock are medium to high levels of pain[63].

Regardless of whether the particular techniques can be properly termed 'pain compliance/management' techniques, there is still a significant issue in terms of the appropriateness of these techniques in a youth detention environment. There is also the potential issue that even if these techniques are considered to be appropriate in certain, limited circumstances it may be that excessive force is being used when these techniques are applied to young people, leading to young people sustaining serious injuries.

[60] Page 26 of the Protective Actions – Induction Training Package, provided by the Department to the Commission on 1 September 2010.
[61] Attachment 1, page 1, provided by the Department of Communities on 1 September 2010.
[62] Attachment 1, page 5.
[63] Page 42 and page 46 of the Protective Actions, Participant Course Notes.

Attachment B - *Summary of the Department's records of processes of complaints and investigation undertaken*

Young Person One	Incident Date: 30 March 2010
Was the Young Person given the chance to complain?	Department did not specify whether Young Person One had been asked if he wanted to make a complaint.
Was the incident referred to another agency (i.e.QPS or CMC)?	The incident was referred internally to the Department, the Queensland Police Service (QPS) and Ethical Standards as a mandatory reportable incident on 31 March 2010.
Was the incident included in the Centre's Harm Report?	The incident was included in the March 2010 Harm report
How was the outcome of the investigation communicated to the Young Person.	Young Person One was not advised that the incident was being investigated.

Young Person Two	Incident Date: 21 September 2009
Was the Young Person given the chance to complain?	The information provided by the Department did not specify whether Young Person Two had been asked if he wanted to make a complaint.
Was the incident referred to another agency (i.e.QPS or CMC)?	Incident reported internally to the Department, QPS, Ethical Standards and the Queensland Ombudsman. Initial inquires commenced immediately by the Ombudsman facilitated by a relevant Departmental officer of Detention Centre One but ceased once the Ombudsman became aware of the other agencies also investigating the incident. QPS commenced their investigation very soon after the matter was reported. The Ethical Standards investigation was placed on hold until the QPS investigation was concluded. QPS have provided an outcome of their investigation to Ethical Standards for review and determination as to what actions need to be undertaken by the Department. The outcome was not conveyed to Young Person Two.
Was the incident included in the Centre's Harm Report?	The incident was included in the Harm report. The incident was also reported by Young Person Two, to the Commission's CVs.
How was the outcome of the investigation communicated to the Young Person.	The Department has not provided any outcome advice to the young person.

Young Person Three	Incident Date: 14 March 2010
Was the Young Person given the chance to complain?	On 15 March 2010 Young Person Three was asked if he wanted to lodge a complaint and he advised that he did not. However, he changed his mind on 19 March and was assisted to lodge a complaint with QPS. The process of the complaint that Young Person Three lodged with QPS was explained to him.
Was the incident referred	Referred to QPS to investigate on 19 March 2010. On 15 March

to another agency (i.e.QPS or CMC)?	the matter was referred internally to the Department and Ethical Standards. QPS investigated the incident and found there were no criminal offences involved in this matter. QPS had interviewed Young Person Three in the presence of relevant family members, who were advised of the investigation process.
Was the incident included in the Centre's Harm Report?	The incident was included in the March 2010 Harm Report. The incident was also reported by Young Person Three, to the Commission's CVs.
How was the outcome of the investigation communicated to the Young Person.	On 16 March 2010, relevant Departmental officers of Detention Centre Two met with Young Person Three's relevant family members. The purpose of the meeting was to explain details of the centre's recruitment process, Youth Worker Induction program and ongoing training that the Department provides to the staff. They also provided an insight in to the Department's Protective Actions training, particularly to transport wrist locks and the use of reasonable force as a last rest. The relevant family members were provided with details of the circumstances of the incident and advised of the incident management process.

Young Person Four	**Incident Date: 21 January 2010**
Was the Young Person given the chance to complain?	Young Person Four was given an opportunity to lodge a complaint. However, chose not to complain to either the centre or QPS.
Was the incident referred to another agency (i.e.QPS or CMC)?	As a result of the injuries sustained by Young Person Four the Centre was required to report the incident internally to the Department. On 9 February 2010 the assessment of allegations was endorsed advising a formal investigation to be conducted. On 19 March 2010 terms of reference for the Investigation had been endorsed and staff involved advised of the allegations. By 7 June 2010 all interviews with Young Person Four, witnesses and subject officers had been completed and the investigation report was prepared.
Was the incident included in the Centre's Harm Report?	The incident was included in the January 2010 Harm Report.
How was the outcome of the investigation communicated to the Young Person.	Up until Young Person Four's release on 21 June 2010, Young Person Four and a relevant family member had been updated on the investigation process.

Young Person Five	**Incident Date: 12 January 2010**
Was the Young Person given the chance to complain?	Young Person Five was given an opportunity to lodge a complaint. However, chose not to complain to either the centre or QPS.
Was the incident referred to another agency (i.e.QPS or CMC)?	As a result of the injuries sustained by Young Person Five the Centre was required to report the incident internally to the Department. On 15 January 2010, the matter was referred to the Department. On 31 May 2010, the Terms of Reference were endorsed and staff members involved in the incident were informed of the allegations. On 8 June 2010, interviews with witnesses and subject officers had commenced. However, due to staff being on leave a further interview had been scheduled for late July 2010. An investigation report was prepared once all interviews had been completed.

Was the incident included in the Centre's Harm Report?	The incident was included in the January 2010 Harm Report.
How was the outcome of the investigation communicated to the Young Person.	On 20 April 2010, Young Person Five was released from custody. Young Person Five was not advised that the Department was conducting a formal investigation into these matters.

Young Person Six	**Incident Date: 17 November 2009**
Was the Young Person given the chance to complain?	Young Person Six chose not to complain to either the Centre or QPS.
Was the incident referred to another agency (i.e.QPS or CMC)?	As a result of the injuries sustained by Young Person Six the Centre was required to report the incident internally to the Department. On 17 November 2009, the matter was referred to the Department. Ethical Standards completed an initial assessment and deemed the incident not a matter of Official Misconduct and referred the matter for local Management Action, to implement strategies to minimise the potential risk of harm. On 13 January 2010, the Department endorsed the Management Action which outlined that a relevant Departmental staff member must complete re-training in Protective Actions.
Was the incident included in the Centre's Harm Report?	The incident was included in the Harm Report 4th Quarter 2009.
How was the outcome of the investigation communicated to the Young Person.	Young Person Six was released from custody on 25 November 2009. Young Person Six was not advised that the Department was conducting an investigation into these matters.

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commission for
children and young people
and child guardian

A better life for Queensland children

Level 17, 53 Albert Street
Brisbane QLD 4000

PO Box 15217
Brisbane City East QLD 4002